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NNS327TAGC STREET ADDRESS, CITY, STATE, ZIP CODE 3008 VENICE DRIVE LEAS YEGAS, INV 38108 SUBMANOY STATEMENT OF DEFICIENCES BY PULL TAG SUBMANOY STATEMENT OF DEFICIENCES BY PULL TAG Y 000 Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 77709. This State Licensure survey acconducted by the authority of NRS 449, 150, Powers of the Health Division. The facility for Group beds for elderly and disabled person and/or persons with mental retardation. The census at the time of the survey was seven. Seven resident files were reviewed and four employee files were reviewed. The facility received a grade of D. The following deficiencies were identified: Y 103 449,200(1)(d) Personnel File - NAC 441A Y 103 Y 103 A49,200(1)(d) Personnel File - NAC 441A Y 103 Y 104 Y 105 Y 106 A49,200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This RULE: is not met as evidenced by: Based on record review on 777/09, the facility of deficiencies are cled, an approved plan of correction is requisite to continued program papticipation. ABORATORY DEEPCRENCY OF ACTION AND CONTINUE (f) The facility of Program papticipation. ABORATORY DEEPCRENCY OF ACTION AND CONTINUE (f) The continued program papticipation. ABORATORY DEEPCRENCY AND AND AND CONTINUE (f) The continued program papticipation.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
VENICE ADULT GROUP INC SUMMERY STATEMENT OF DEPOID ROUSE PRESTY TAG SUMMERY STATEMENT OF DEPOID ROUSE (REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMERY STATEMENT OF DEPOID ROUSE (REGULATORY OR LSC IDENTIFYING INFORMATION) PRESTY TAG PRESTY TAG PRESTY TAG PRESTY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PRESTY TAG PRESTY TAG			NVS3277A	GC	B. WING _		07/07	/2009
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PRETIX TAG Y 000 Initial Comments Y 000 Initial Comments Y 000 Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 77/709. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for ten Residential Facility of Group beds for elderly and disabled person and/or persons with mental retardation. The census at the time of the survey was seven. Seven resident file were reviewed. One discharged resident file was reviewed. The facility received a grade of D. The following deficiencies were identified: Y 103 449.200(1)(d) Personnel File - NAC 441A SS=F NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This RULE: is not met as evidenced by: Based on record review on 7/7/09, the facility If deficiencies are cited, an approved plan of correction is requisite to continued program payticipation.	VENICE A	ADULT GROUP INC						
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(d) The health certificates required pursuant to chapter 441A of NAC for the employee. (d) The health certificates required pursuant to chapter 441A of NAC for the employee. (d) The health certificates required pursuant to chapter 441A of NAC for the employee. (d) The health certificates required pursuant to chapter 441A of NAC for the employee. (d) The health certificates required by a chapter 441A of NAC for the employee. (d) The health certificates required by a chapter 441A of NAC for the employee. (d) The health certificates required by a chapter 441A of NAC for the employee. (d) The health certificates required pursuant to chapter 441A of NAC for the employee. (d) The health certificates required pursuant to chapter 441A of NAC for the employee. (d) The health certificates required pursuant to chapter 441A of NAC for the employee. (d) The health certificates required pursuant to culosis conducted by a physician marked as Attachment 41. (e) All Employee files will be reviewed every 6 months to consume a complete requirements in TB Screening, A Physician TB Screening, A Physician TB Screening, A Physician TB Screening, A Physician marked as Attachment 41.	Y 103	The findings and copy the Health Divisi prohibiting any crimactions or other cla available to any parstate, or local laws. This Statement of Daresult of an annuaconducted at your flicensure survey wor NRS 449.150, Portion of NRS 449.150, Portion	ion shall not be constinal or civil investigatims for relief that marty under applicable for the constitution of the constitution of the survey was were reviewed and a reviewed. The facility relief the constitution of the survey was were reviewed and a reviewed. One discoviewed. The facility relief the constitution of the survey was were reviewed and a reviewed. The facility relief the constitution of the survey was sure reviewed. One discoviewed. The facility relief the constitution of the survey was sure reviewed. One discoviewed. The facility relief the constitution of the constitution of the survey was sure reviewed. One discoviewed. The facility relief the constitution of	trued as tions, by be ederal, erated as rvey is State authority Division. htial isabled rdation. as seven. four charged eceived a		RECE JUL 2 EUREAU OF LICENSUR LAS YEGAS	3 2009 E AND CERTIFICATION E, NEVADA and a history	TY
- <i>1</i> 1		Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This RULE: is not met as evidenced by:				culosis conducted physician marked Attachment #1. B. All Employee files a reviewed every 6 me ensure employee complete requireme.	by a as will be onthat to has a ants in	7/23/69

If continuation sheet 1 of 7

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Y 103 Continued From Page 1 failed to ensure 1 of 4 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #2) for the protection of 7 of 7 residents (Resident #1, #2, #3, #4, #5, #6 and #7). Severity: 2 Scope: 3 Y 105 A49.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This RULE: is not met as evidenced by: Based on record review on 777/09, the facility failed to ensure 1 of 4 caregivers had background checks completed (Employee #4), Employee #4 failed to have a signed criminal history statement, FBI check and finger prints. This was a repeat deficiency from the 9/10/08 State Licensure survey. Severity: 2 Scope: 1 Y 274 449.2175(5) Service of Food - Substitutions Y 103 Evaluation for achive them eclosis, chest X-nay and follow up assess ment for signs and Symptoms of Tubercologis; chest X-nay and follow up assess ment for signs and Symptoms of Tubercologis; s, chest X-nay and eclosis, chest X-nay and follow up assess ment for signs and Symptoms of Tubercologis; s, chest X-nay and eclosis, chest X-nay and follow up assess ment for Signs and Symptoms of Tubercologis; s, chest X-nay and eclosis, chest X-nay and follow up assess ment for Signs and Symptoms of Tubercologis; s, chest X-nay and eclosis; s to be done eclosis; chest X-nay and eclosis; chest X-nay and follow up assess ment for Signs and Symptoms of Tubercologis; s to be done eclosis; chest X-nay and eclosi									
VENICE ADULT GROUP INC 3898 VENICE DRIVE LAS VEGAS, NV 89108	AND PLAN OF CORRECTION IDENTIFICATION I		IDENTIFICATION NU	MBER:	A. BUILDIN		COMPLETED		
VENICE ADULT GROUP INC 3898 VENICE DRIVE LAS VEGAS, NV 89108	NAME OF P	ROVIDER OR SUPPLIER			DRESS, CITY,	STATE, ZIP CODE			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Y 103 Continued From Page 1 failed to ensure 1 of 4 caregivers complied with NAC 441A 375 regarding tuberculosis testing (Employee #2) for the protection of 7 of 7 residents (Resident #1, #2, #3, #4, #5, #6 and #7). Severity: 2 Scope: 3 Y 105 A 249.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This RULE: is not met as evidenced by: Based on record review on 777/09, the facility failed to ensure 1 of 4 caregivers had background checks completed (Employee #4). Employee #4 failed to have a signed oriminal history statement, FBI check and finger prints. This was a repeat deficiency from the 9/10/08 State Licensure survey. Severity: 2 Scope: 1 Y 274 449.2175(5) Service of Food - Substitutions Y 274 Y 274 449.2175(5) Service of Food - Substitutions		VENICE ADULT GROUP INC 3508 VEN			ICE DRIVE				
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SS=C	Y 105 SS=D	failed to ensure 1 of NAC 441A.375 reg (Employee #2) for residents (Residen #7). Severity: 2 So 449.200(1)(f) Persocheck NAC 449.200 1. Except as otherwal a separate personn member of the state (f) Evidence of com 449.185, inclusive. This RULE: is not Based on record regailed to ensure 1 of background checks Employee #4 failed history statement, If this was a repeat of State Licensure sure Severity: 2 Social Severity: 2 Soci	of 4 caregivers complarding tuberculosis to the protection of 7 of the protection of 7 of the 1, #2, #3, #4, #5, #4 ope: 3 onnel File - Background of a facility and must be kept of a facility and must pliance with NRS 44 operations are evidenced by eview on 7/7/09, the first 4 caregivers had as completed (Employ to have a signed crief and finger deficiency from the 9 ovey.	esting 7 #6 and section 2, for each st include: 19.176 to cacility ree #4). minal prints. /10/08	Y 105	culosis, chest X follow up asses signs and Sym Tuberculosis is annually after has been doce Administrator for compliance C. 7/17/09 Y 105 A. Employee # 4 S Winimal History dated July 8, Fingerprint and result marked a # 2 B. All Employee fil reviewed every to ensure emplo Completed and all the require needed for Bac Check The Administra monitor for ce	ray and sment for ploms of for be done to pe	203	
		449.2175(5) Service NAC 449.2175	e of Food - Substitut	ions	Y 274				

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING NVS3277AGC 07/07/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3508 VENICE DRIVE** VENICE ADULT GROUP INC LAS VEGAS, NV 89108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) Y 274 Y 274 Continued From Page 2 Y 274 A. A Menu was written and place during the service of the meal. posted at the facility. Any substitution for menu must be documented by writing on the bottom of menu plan. This RULE: is not met as evidenced by: Attachment # 3 (Menu-Based on observation and interview on 7/7/09, the facility failed to ensure menu substitutions substitute) B. Advised caregiver to write down the substitute were documented and retained for at least 90 days. The facility did not follow the scheduled menu for 2 of 2 meals observed today. food on the bottom of the menu if theres any This is a repeat deficiency from the 4/40/09 complaint survey. changes. Administrator will monitor Severity: 1 Scope: 3 for compliance. C. 7/17/09 Y 353√ Y 353 449.222(3) Bathrooms and Toilet Facilities SS=E Y 353 NAC 449.222 A. Grab Bars were installed 3. The bottoms of tubs and showers must have in the Bathroom of bedroom surfaces that inhibit falling and slipping. #8 and Bedroom #1 Cabinets that are attached to the floor or grab Attachment # # proture bars must be adjacent to the tubs, toilets and showers. B. Administrator will ensure that all bathrooms had This RULE: is not met as evidenced by: a grab bars for the safety of all residents Based on observation on 7/7/09, the facility failed to ensure grab bars adjacent to the tub in 2 of 5 Administrator will monitor bathrooms. The bathroom in bedroom #8 and for compliance. the bathroom in Bedroom #1. C. 7/17/09 Severity: 2 Scope: 2

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAC 449.222

449.222(6) Bathrooms and Toilet Facilities

Bathroom doors that are equipped with locks

Y 356

SS=D

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Y 356 / Y 356

Confinuation sheet 3 of 7

A. The locks in the Caregiver

bathroom was changed

to a single motion lock,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING NVS3277AGC 07/07/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3508 VENICE DRIVE VENICE ADULT GROUP INC LAS VEGAS, NV 89108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) Y 356 Continued From Page 3 Y 356 so it can be openable inside and outside of the bathroom must open with a single motion from the inside Attachment # 51 picture without the use of a key. If a key is required to & receipt) . open a lock from outside the bathroom, the key B. Administrator will ensure must be readily available at all times. that all bathroom locks must have a single This RULE: is not met as evidenced by: Based on observation on 7/7/09, the facility failed motion. Administrator will monitur to ensure single motion locks on 1 of 5 for compliance. bathrooms. The bathroom designated as the "caregivers" bathroom has a two motion lock. C-7/17/09. Severity: 2 Scope: 1 Y 285 Y 885 Y 885 V 449.2742(9) Medication / Destruction A All Medication that are SS=F NAC 449.2742 discontinued or belongs 9. If the medication of a resident is discontinued, to Discharge resident or the expiration date of the medication of a expired resident was resident has passed, or a resident who has been discharged from the facility does not claim the already destroyed on medication, an employee of a residential facility A-pril 7, 2009 shall destroy the medication, by an acceptable Attachement # 6 medicaha method of destruction, in the presence of a witness and note the destruction of the Destruction Records medication in the record maintained pursuant to B. Medication that is Dis-NAC 449.2744. Flushing contents of vials, continued or belongs to bottles or other containers into a toilet shall be discharged resident or deemed to be an acceptable method of destruction of medication. expired resident mushe

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This RULE: is not met as evidenced by:

were discontinued, had expired or after a

resident had been transferred.

Based on observation and interview on 7/7/09.

the facility failed to destroy medications after they

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C. 7/9/09

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destroyed right away. Administrator will conduct a random check on the medication cabinet and

caregiver room once

every month.

(X5)

COMPLETE

DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS3277AGC 07/07/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3508 VENICE DRIVE VENICE ADULT GROUP INC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 885 Continued From Page 4 Y 885 Severity: 2 Scope: 3 Y 898 449.2744(1)(b)(4) Medication / MAR Y 898 V IV 898 A. Employee # 3 Administeral SS=C the medication on 7/6/09 PM and 7/9/09 AM but NAC 449.2744 forget to sign it . Caregiver 1. The administrator of a residential facility that provides assistance to residents in the signed M.A.R's at the administration of medication shall maintain: time of survey. Copy of (b) A record of the medication administered to each resident. The record must include: M.A.R's Attachment # 7 (4) Instructions for administering the B. Remind Caregiver to medication to the resident that reflect the current sign the M.A.R. at the order or prescription of the resident's physician. same time upon adminis tering the medication for each resident. Administrator will check This RULE: is not met as evidenced by: the M.A.R's every week Based on record review on 7/7/09, the facility to ensure that all medifailed to ensure the medication administration cines are given correctly Administrator will monitor for C. 7/17/09. Compliance. record (MAR) was accurate for 7 of 7 residents (Resident #1, #2, #3, #4, #5, #6 and #7). Severity: 1 Scope: 3 Y 920 449.2748(1) Medication Storage Y 920~ y 920 A. All Medication found in SS=F

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

1. Medication, including, without limitation, any

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NAC 449.2748

over-the-counter medication.

facility must be stored in a locked area that is cool and dry. The

caregivers employed by the facility

shall ensure that any medication or

stored at a residential

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If continuation sheet 5 of 7



the caregiver room was

during the survey

B. All medication must be

destroyed on July 7, 2009

(medication Destruction

Record - Attachment #8)

Stored in a locked cabinet

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU				(X3) DATE SURVEY COMPLETED	
		NV\$3277A				07/0	7/2009
NAME OF	PROVIDER OR SUPPLIER				STATIE, ZIP CODE		
VENICE	ADULT GROUP INC			NICE DRIVE 3AS, NV 891	08		,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTK CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
Y 920	of administering me without supervision medication in his ro medication is kept i container for which been provided a ke This RULE: is not a Based on observati to keep medications locked area (Reside #7).	tic equipment that appropriated by a ser unauthorized. Medication for sust be kept in a ste from other dent who is capable edication to himself may keep his som if the n a locked the facility has	ility failed s in a	Y 920	and should be lock area at Employee was for storing all tinued medical room. Administrate for complian C. 7/1/09.	all times. I disciplined the discon- ines to hov will monitor	
Y 923 SS=F	over-the-counter me supplement, must b	ding, without limitatio	-	Y 923 V	A, All the medical inside the Cantainer was on Soly 7, 2005 B. All Medication over the count must be kept original container adiscontinued.	regiver Room the original destroyed ion including ter medication on their winer.	

f deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION			PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SI COMPLE		
NAME OF P	ROVIDER OR SUPPLIER	14932117		DRESS CITY	STATE, ZIP CODE	07707	12009	
1	ADULT GROUP INC		ľ	ICE DRIVE	OTATE, ZII GODE			
VERNOL	ADDET ONCO, INC			AS, NV 891	08			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMP		
Y 923	Continued From Pa	age 6		Y 923	to Discharged	Resident		
					to Discharged on must be kept original conto Administrator	on the		
					original conto	ainer and		
	This RULE: is not	met as evidenced by	<i>r</i> :		Administrator	will destroy		
		ion on 7/7/09, the fac			right away. A will moritor fin	doministrator		
		is in their original cor nts. Medications wer			C. 7/7/09	compliance		
		proximately 10 ziplo			C . ////04			
	medications withou	it names or prescript	ions were					
	found unlocked in t	the caregiver's bedro	om.					
	Severity: 2 Sco	pe: 3						

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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